

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

**2.2 PARAMETERS FOR THE INITIAL PSYCHIATRIC
ASSESSMENT OF OLDER ADULTS IN EMERGENCY ROOMS AND ON
INPATIENT UNITS**

January 2002

I. THE ASSESSMENT ENVIRONMENT

The assessment environment should:

- A. Be ADA compliant and accessible through the use of clear signage, easily understood phone messages and instructions, clear and simple appointment procedures, and clear and simple documentation requirements;
- B. Accommodate the need for the presence of caregivers or loved ones during the assessment process;
- C. Respect the special concern for modesty that is present in the current older adult cohort;
- D. Accommodate for impaired psychomotor abilities through use of non-slip floors and chairs with arms;
- E. Accommodate for impaired sensory ability through use of bright but non-glare lighting, large lettering on signage, and minimal background noise; and
- F. Accommodate for painful conditions and other physical limitations through use of pillows, other positioning aids, warm instruments, and easily available toilet facilities.

II. HISTORY TAKING AND THE CLINICAL INTERVIEW

- A. Attempts should be made to obtain medical records from care facilities and to document findings in the current medical record.
- B. Attempts should be made to obtain collateral information from family and other caregivers, respecting confidentiality and autonomy as appropriate.

- C. The interview situation should be one that ensures privacy, sensory accommodation, safety, and adequate time to accommodate cognitive slowing when present.
- D. Medical and surgical history should be obtained and documented.
- E. History of recent trauma and falls should be obtained and documented.
- F. The interview should include assessment for neglect and possible physical, psychological, and/or financial abuse.

III. PHYSICAL/NEUROLOGICAL EXAMINATION

- A. A screening examination should occur within 6 hours of arrival, and a comprehensive physical examination should be completed within 24 hours of admission. At a minimum the examinations should include and document observations and tests to determine presence or absence of the following:
 - 1. Malnutrition,
 - 2. Generalized or localized pain,
 - 3. Oral compromise,
 - 4. Sensory impairment,
 - 5. Podiatric complaints,
 - 6. Gait disturbance,
 - 7. Abdominal or superficial masses,
 - 8. Cardiopulmonary problems, and
 - 9. Dermatological lesions.
- B. Blood pressure: Orthostatic measurements of BP and pulse should be obtained and recorded.
- C. Weight: initial weight should be obtained and recorded.
- D. Cognitive function:
 - 1. Confusion Assessment Method (CAM) procedure should be used to assess for delirium.
 - 2. Folstein Mini Mental Status Exam, Pfeifer Mental Status Exam, or Short Portal Mental Status should be used to assess for symptoms of cognitive impairment.
- E. Permission should be sought to complete a rectal and genitourinary examination whenever appropriate (e.g., not performed within last 6 months, history of GU complaints),

the consent or refusal should be documented in the medical record, and the examination should be performed and recorded in all consenting individuals.

IV. MENTAL STATUS EXAMINATION

- A. A screening examination should occur within 6 hours of arrival, and a comprehensive mental status examination should be completed within 24 hours of admission.
- B. Direct inquiry regarding suicidal ideation, intent, and plan should be made with all patients who present with depressive symptoms or self-injury, overdose, treatment refusal, significant neglect of self-care, and the results documented.
- C. Emotional status should be assessed in all individuals using the Geriatric Depression Scale, and the results documented.
- D. Direct inquiry regarding unusual beliefs or irresistible impulses should be made with all individuals who present with bizarre or eccentric behavior, including hoarding, reclusiveness, extreme suspiciousness or hostility, and the results documented.
- E. Direct inquiry regarding particular causes of worry or apprehension should be made in all patients who present with significant anxiety, and the results documented.

V. FUNCTIONAL ASSESSMENT

- A. Determination of adequacy of executive function should be determined in relation to adaptive demands.
- B. The Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL) Assessment Instruments should be administered and documented for all patients.
- C. Living situation, including safety and degree of independence, should be documented.
- D. Ability to self-administer medication should be assessed and documented.

VI. SUBSTANCE USE

- A. A full medication review, including types and dosages, and compliance for all prescribed, non-prescribed, and alternative drugs should be sought and documented
- B. Direct inquiry regarding use of alcohol, benzodiazepines and other recreational drugs should be made and documented.
- C. The Complaint-Annoyed-Guilty-Eye-opener (CAGE) assessment instrument should be used for all individuals who admit to regular alcohol use
- D. Third party history regarding substance use should be sought whenever available.

VII. LABORATORY ASSESSMENT

- A. Appropriate laboratory investigations should be obtained for all abnormal findings in history or physical.
- B. Essential Laboratory Investigation: CBC, electrolytes, thyroid function (TSH, T4), vitamin B12, folate, serology for syphilis, glucose, calcium, BUN, creatinine, UA with C&S, LFTs, albumin and globulin, occult blood.
- C. Essential Imaging: CXR, CT or MRI.
- D. Essential cardiovascular assessment: EKG.

VIII. OPTIONAL LABORATORY ASSESSMENT

- A. **Cognitive impairment:** SPECT and or neuropsychiatric testing should be used whenever cognitive impairment is present without obvious etiology
- B. **Delirium:** Lumbar puncture (LP) and EEG should be obtained in all individuals who present with delirium without obvious etiology.
- C. **Suspected Seizure Disorder:** EEG should be obtained in all individuals who present with delirium of unknown etiology or evidence of seizure disorder.

- D. **Suspected Drug Toxicity:** Relevant toxicologies should be obtained in all individuals in whom history, signs or symptoms suggest danger of drug toxicity.
- E. **HIV Risk:** HIV testing should be obtained in all individuals with risk factors for HIV infection, e.g., history of blood transfusion, high-risk sexual activity, and intravenous drug use.
- F. **Unexplained malaise, pain, or cognitive impairment:** Blood cultures should be obtained in all individuals with unexplained malaise, pain, or cognitive impairment.
- G. **Pulmonary compromise:** ABGs should be obtained in all individuals with cognitive impairment and evidence of pulmonary compromise, e.g. COPD.